For DHHS Use Only

CON Application Number
Facility Number
Date Submitted

APPLICATION FOR CERTIFICATE OF NEED
EXTENDED CARE SERVICES (Swing Bed) PROGRAM

Michigan Department of Health & Human Services
Certificate of Need
South Grand Building
333 S. Grand Avenue, 4th Floor
Lansing, Michigan 48933
Phone: (517) 241-3344 Fax: (517) 241-2962

AUTHORITY: PA 368 of 1978, as amended **COMPLETION:** Is voluntary, but is required to obtain a Certificate of Need. If not completed, a Certificate of Need will not be issued.	The Department of Health & Human Services is an equal opportunity employer, services and programs provider.

Pursuant to MCL 333.22210, there is no fee for an Extended Care Services (Swing Bed) Program application. Please note applications can be submitted only for licensed hospitals.

1. Legal Name of Applicant *(Must be exactly the same as Section 2 on Letter of Intent)*			
2. Current Licensed Name of Hospital			County
3. Proposed Licensed Name of Facility or Proposed Name of Center			
4. Facility / Center Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

5. Legal Owner of Building (*if other than applicant*)			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
6. Legal Owner of Land (*if other than applicant*)			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

7. Curre**nt Licensee of Facility** (*if other than applicant*)			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code

CERTIFICATIONS

EXTENDED CARE SERVICES PROGRAM

A. I certify that the information and attachments submitted are true and correct. I further certify that no revisions will be made to the approved project, including bed count or provision of additional or expanded services and space, without first notifying and receiving approval from the Department of Health & Human Services to make such revisions, and where applicable, to the Alliance for Health.

B. I understand that the Certificate of Need application process, decision, and subsequent operation of the proposed project (if approved) are subject to the applicable laws and rules.

C. I understand that by submitting this application that applicant agrees (if approved) to comply with all the requirements set forth in Section 22210(3).

CERTIFICATION ACCEPTANCE

Signature of Authorized Agent	Date Signed

CERTIFICATE OF APPOINTMENT FOR AUTHORIZED AGENT

Michigan Department of Health & Human Services

Notice is hereby given to the Michigan Department of Health & Human Services that

_____

[Legal name of applicant entity (same as Page 1, Line #1)]

has appointed and authorized the following person to act on behalf of the applicant entity.

Agent Name	Title		
Name of Agent's Organization			
Street Address *(Street & Number or P.O. Box)*	City	State	ZIP Code
Agent's Telephone Number Extension	Agent's Fax Number Extension		
Agent's E-Mail Address			

THE ABOVE NAMED AGENT IS THE AUTHORIZED REPRESENTATIVE FOR CERTIFICATE OF NEED NUMBER:

_____

(Certificate of Need Number)

The above named agent is authorized to do the following:

A. submit this Certificate of Need application and make amendments thereto,

B. provide the Department with all information necessary for a determination with respect to this Certificate of Need application,

C. enter into agreements with the Department in connection with this Certificate of Need, and

D. receive notice and service of process in matters relating to this Certificate of Need.

- This appointment will remain in effect for this application until written notice of termination is sent to the Michigan Department of Community Health that references the specific CON application number.
- The termination notice must identify a new authorized agent.

Typed Name	Signature of Individual Legally Authorized to Appoint Agent *(Original signature only)*
Title	

OTHER CONTACT PERSONS:

FINANCIAL DATA: (Person's Name)	ALL OTHER DATA: (Person's Name)
Telephone Number Extension	Telephone Number Extension
E-mail Address	E-mail Address

PROPOSED PROJECT

1. Provide a detailed description of the proposed project, including the location of the swing bed program (e.g., wing name, building, etc.), number of beds to be designated, and any construction or renovation as applicable.

2. The hospital has a total of ___ licensed hospital beds. Pursuant to Sec. 22210(1)(b), the hospital must have fewer than 100 licensed beds, not counting beds excluded under section 1883 of title XVIII of the social security act.

3. Indicate number of licensed hospital beds that will be used for extended care services program (up to a maximum of 10 beds): __

4. Indicate the room numbers where the above extended care services program beds will be located:

5. Pursuant to Sec. 22210(1)(c), does the hospital (applicant) have any uncorrected licensing, certification, or safety deficiencies for which the Department or the state fire marshall, or both, has not accepted a plan of correction? ☐ Yes ☐ No

If yes, please describe:

6. The applicant agrees (if approved) to comply with all the requirements set forth in Section 22210(3)?
☐ Yes ☐ No

7. Pursuant to Sec. 22210(1)(d), provide below evidence that the hospital has had difficulty in placing patients in skilled nursing home beds during the most recent 12 months. (*Use additional sheets if needed*)

Patient ID (HIPAA Compliant)	Date Transfer Attempted	Name of Nursing Home(s) Unable to Receive Patient

8. Does the hospital (applicant) owns or operates a hospital long-term care unit, as defined in MCL 333.20106?
☐ Yes ☐ No